aneurysm (AAA) but is associated with more late reinterventions compared with open repair. This study compares the outcomes from EVAR and open repair in the Vascular Study Group of New England (VSGNE).

Methods: We reviewed all elective, nonruptured symptomatic, and ruptured endovascular and open repairs of AAA from 2003-2012. Postoperative reinterventions, morbidity, and mortality were compared at the 30-day, 30-day to 1-year, and overall 1-year follow-up.

Results: We identified 3347 EVARs and 2251 open repairs. At 30 days and 1 year, overall reintervention rates were higher after open repair compared with EVAR (Table). Between 30 days and 1 year, reinterventions were less after elective open repair compared with EVAR (2.6% vs 3.8%, $P = .03$) but were similar after open repair and EVAR for symptomatic (4.5% vs 4.6%, $P = .97$) and ruptured (5.5% vs 4.3%, $P = .58$) AAA. Mortality was lower after elective EVAR compared with open repair at 30 days (1.6% vs 2.6%, $P = .01$) but was similar at 1 year (7.2% vs 7.3%, $P = .88$).

Conclusions: Reintervention was more common after open repair compared with EVAR across all AAA repair in the perioperative period. Between 30 days and 1 year, EVAR had higher reintervention rates for elective AAA repair but was similar to open repair for symptomatic and ruptured AAA.

Table. Reintervention rates for all patients undergoing endovascular aneurysm repair (*EVAR*) vs open abdominal aortic aneurysm repair

Reinterventions	*EVAR* (*n = 3347*) (%)	*Open* (*n = 2251*) (%)	P
30-day reinterventions	1.9	11.5	<.01
Multiple reinterventions	0.3	2.2	<.01
Leg embolization	0.8	1.6	<.01
Bowel ischemia	0.5	2.5	<.01
Wound complication	0.4	3.1	<.01
Hemorrhage	0.6	2.7	<.01
Return to operating room	10.8 (*n = 3002*)	10.9 (*n = 2140*)	<.01
30-day to 1-year reinterventions	3.8	3.3	.29
Multiple reinterventions	1.3	0.6	<.01
Total 1-year reinterventions	5.5	13.2	<.01

Author Disclosures: R. Bensley: Nothing to disclose; **C. Feng**: Nothing to disclose; **M. Schermerhorn**: Nothing to disclose.

PS6

Effectiveness and Cost of Different Intravenous Drugs Used for Patients Presenting With Acute Stanford Type B Aortic Dissection

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Objectives: The purpose of this study is to determine the cost differences associated with different intravenous (IV) blood pressure medications used in the treatment of acute Stanford type B aortic dissections.

Methods: A retrospective record review was conducted of patients treated for an acute type B aortic dissection between June 2006 and September 2013 to determine the IV blood pressure medication regimen (a combination of labetalol, esmolol, nitroprusside, and/or nicardipine). Patients receiving each IV infusion were compared with patients not receiving that drug with regards to the total cost of the infusion, mortality, the complication rate associated with the dissection, and the need for operation.

Results: Ninety patients were treated with IV blood pressure medications for an acute type B dissection. The in-hospital mortality rate was 11.1%, 33.3% experienced a complication of their dissection, and 4.4% had an operation after an initial attempt at medical therapy. Fifty-three percent of patients received an esmolol infusion, 46% a nicardipine infusion, 41% a labetalol infusion, and 54% a nitroprusside infusion. Median cost of admission was $66,355 (interquartile range, $41,372-$160,176), and median cost of the infusions was $4837 (interquartile range, $1922-$13,240). Esmolol was associated with increased total drug cost (median, $10,545 vs $1947; $P < .001$) and longer intensuve care unit (ICU) stays (median, 5 vs 3 days; $P = .025$). Nicardipine carried increased cost ($11,195 vs $3365, $P < .001$) and longer ICU stay (5 vs 3 days, $P = .058$). Labetalol carried decreased cost (median $3931 vs $9136, $P = .004$) with no difference in ICU stay (3 vs 3 days; $P = .175$). Nitroprusside carried no difference in cost ($5095 vs $4038; $P = .182$). No drug was associated with increased mortality, need for operation, or complication of the dissection.

Conclusions: Labetalol and nitroprusside are significantly cheaper medications to treat acute type B aortic dissections, and they are not associated with increased risk of death, complication of the dissection, or need for operation.

Author Disclosures: K. Maxfield: Nothing to disclose; **T. Naslund**: W. L. Gore, Aptus Endosystems, and CVRx, consulting fees or other remuneration (payment); **A. Richter**: Nothing to disclose; **C. Sheng**: Nothing to disclose.

PS8

Flap Thickness in Type B Aortic Dissection Predicts Aneurysmal Expansion

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Objectives: We sought to demonstrate the prognostic implication of flap thickness (FT) in type B aortic dissection (TBAD).

Methods: A retrospective review was undertaken of all patients with TBAD from June 2006 to June 2012. Demographics, hospital course, imaging, and follow-up visits were analyzed. FT on computed tomography angiography (CTA) was measured using full width at half maximum technique. Survival rates and predictors of outcome were determined using the Kaplan-Meier method with Cox proportional hazards.

Results: Of 134 patients with TBAD, 101 (75%) had a classical dissection and 33 (24%) had atypical dissection (no dissection flap). FT analysis was available in 63 patients (38 men), with a mean age of 64 ± 15 years. Median follow-up was 33 (0-135) months. Sixteen patients underwent